

§ 488.105 Long term care survey forms, Part B.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0000

PART B
MEDICARE / MEDICAID SKILLED NURSING FACILITY AND INTERMEDIATE CARE FACILITY SURVEY REPORT

PROVIDER NUMBER _____

VENDOR NUMBER _____

SURVEY DATE _____

FACILITY NAME AND ADDRESS (City, State, Zip) _____

SURVEYORS' NAMES _____

TITLES _____

SURVEY TEAM COMPOSITION

F1 Indicate the Number of Surveyors According to Discipline.

A. Administrator	
B. Nurse	
C. Dietitian	
D. Pharmacist	
E. Records Administrator	
F. Social Worker	
G. Qualified Mental Health Professional	

Note: More than one discipline may be marked for surveyors qualified in multiple disciplines.

F2 Indicate the Total Number of Surveyors Onsite: _____

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(CONTINUED ON REVERSE)

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RESIDENT CENSUS AND CONDITIONS OF RESIDENTS			
PROVIDER NO. _____		<input type="checkbox"/> F3 MEDICARE	<input type="checkbox"/> F4 MEDICAID
		<input type="checkbox"/> F5 OTHER	F6 TOTAL RESIDENTS _____
CODE		CODE	
BATHING		CONTINENCE	
F7	Number of residents requiring assistance in bathing more than one part of body—or does not bathe self.	F22	Number of residents with indwelling or external catheters.
F8	Number of residents requiring assistance in bathing only a single part (as back or disabled extremity) or bathes self completely.	F23	Number of residents with partial or total incontinence in urination or defecation—partial or total control by suppositories or enemas, regulated use of urinals and/or bedpans.
F9	TOTAL*	F24	Number of residents with urination and defecation entirely self-controlled.
DRESSING		F25	TOTAL*
F10	Number of residents totally dressed by another person.	FEEDING	
F11	Number of residents needing assistance to dress self or remain partly dressed. (Exclude those residents totally dressed.)	F26	Number of residents who receive enteral/parenteral feedings.
F12	Number of residents able to get clothes from closets and drawers—puts on clothes, outer garments, braces—manages fasteners. Act of tying shoes is excluded.	F27	Number of residents who receive NG tube feedings.
F13	TOTAL*	F28	Number of residents who require assistance in act of eating.
TOILETING		F29	Number of residents who get food from plate or its equivalent into mouth—(pre-cutting of meat and preparation of food, buttering bread, opening cartons, removing plate covers, etc., are excluded from evaluation).
F14	Number of residents not toileted. (Use protective padding, catheter.)	F30	TOTAL*
F15	Number of residents who must use a bedpan or commode and/or receive assistance in getting to and using a toilet.	F31	Number of completely bedfast residents.
F16	Number of residents able to get to toilet—gets on and off toilet—cleans self—arranges clothes.	F32	Number of chairbound residents.
F17	TOTAL*	F33	Number of ambulatory residents (may use cane, walker, or crutches).
TRANSFERRING		F34	Number of physically restrained residents (belt, vest, cuffs).
F18	Number of residents needing assistance in all transfers (moving in or out of bed and/or chair, toilet, tub transfers).	F35	Number of residents receiving psychotropic drugs.
F19	Number of residents needing assistance in transferring to toilet and tub only.	F36	Number of confused or disoriented residents.
F20	Number of residents able to complete all transfers independently (may or may not be using mechanical supports).	F37	Number of residents with decubiti.
F21	TOTAL*	F38	Number of residents on individually written bowel and bladder retraining program.
		F39	Number of residents receiving special skin care.
		F40	Number of residents receiving intravenous therapy and/or blood transfusion.
		F41	Number of residents requiring no assistance in ADLs.
		F42	Number of residents on self-administration of drugs.
		F43	Number of residents with contractures.
		F44	Number of residents receiving respiratory care.
		F45	Number of residents receiving tracheostomy care.
		F46	Number of residents receiving suctioning.
		F47	Number of residents receiving rehabilitative services (physical therapy, speech pathology and audiology, occupational therapy)
		F48	Number of residents receiving injections.
		F49	Number of residents receiving colostomy care.

NAME OF FACILITY		GOVERNING BODY		YES	NO	N/A	EXPLANATORY STATEMENT
CODE	GOVERNING BODY (CONDITION OF PARTICIPATION)						
F50	SNF (405.1121) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET						
F51	RESIDENT RIGHTS SNF (405.1121(k)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET Indicators A thru K apply to this standard for SNFs						
F52	ICF (442.311) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET Indicators A thru K apply to this standard for ICFs						
	A. Information						
F53	1. The facility informs each resident, before or at the time of admission, of his/her rights and responsibilities.						
F54	2. The facility informs each resident, before or at the time of admission, of all rules governing resident conduct.						
F55	3. The facility informs each resident of amendments to their policies on residents' rights and responsibilities and rules governing conduct.						
F56	4. Each resident acknowledges in writing receipt of residents' rights information and any amendment to it.						
F57	5. The resident must be informed in writing of all services and charges for services.						
F58	6. The resident must be informed in writing of all changes in services and charges before or at the time of admission and on a continuing basis.						
F59	7. The resident must be informed of services not covered by Medicare or Medicaid and not covered in the basic rate.						

NAME OF FACILITY

CODE	GOVERNING BODY	YES	NO	N/A	EXPLANATORY STATEMENT
	B. Medical Condition and Treatment				
F60	1. Each resident is informed by a physician of his/her health and medical condition unless the physician decides that informing the resident is medically contraindicated.				
F61	2. Each resident is given an opportunity to participate in planning his/her total care and medical treatment.				
F62	3. Each resident is given an opportunity to refuse treatment.				
F63	4. Each resident gives informed, written consent before participating in experimental research.				
F64	5. If the physician decides that informing the resident of his/her health and medical condition is medically contraindicated, the physician has documented this decision in the resident's medical record.				
	C. Transfer and Discharge				
	Each resident is transferred or discharged only for:				
F65	1. Medical reasons.				
F66	2. His/her welfare or that of other residents.				
F67	3. Nonpayment except as prohibited by the Medicare or Medicaid program.				
F68	4. Each resident is given reasonable advance notice to ensure orderly transfer or discharge. EXCEPTION: Not required for ICF residents.				
	D. Exercising Rights				
F69	1. Each resident is encouraged and assisted to exercise his/her rights as a resident of the facility and as a citizen.				
F70	2. Each resident is allowed to submit complaints and recommendations concerning the policies and services of the facility to staff or to outside representatives of the resident's choice or both.				

NAME OF FACILITY		GOVERNING BODY	YES	NO	N/A	EXPLANATORY STATEMENT
F71	3. Such complaints are submitted free from restraint, coercion, discrimination, or reprisal.					
E. Financial Affairs						
F72	1. Residents are allowed to manage their own personal financial affairs.					
F73	2. The facility establishes and maintains a system that assures full and complete accounting of residents' personal funds. An accounting report is made to each resident in a skilled nursing facility at least on a quarterly basis.					
F74	3. The facility does not commingle resident funds with any other funds.					
F75	4. If a resident requests assistance from the facility in managing his/her personal financial affairs, resident's delegation is in writing.					
	5. The facility system of accounting includes written receipts for:					
F76	All personal possessions and funds received by or deposited with the facility.					
F77	All disbursements made to or for the resident.					
F78	6. The financial record must be available to the resident and his/her family.					
F. Freedom from Abuse and Restraints						
F79	1. Each resident is free from mental and physical abuse.					
F80	2. Chemical and physical restraints are only used when authorized by a physician in writing for a specified period of time or in emergencies.					

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NAME OF FACILITY

CODE	GOVERNING BODY	YES	NO	N/A	EXPLANATORY STATEMENT
F81	3. If used in emergencies, they are necessary to protect the resident from injury to himself/herself or others.				
F82	4. The emergency use is authorized by a professional staff member identified in the written policies and procedures of the facility.				
F83	5. The emergency use is reported promptly to the resident's physician by the staff member.				
	G. Privacy				
F84	1. Each resident is treated with respect, consideration and full recognition of his/her dignity and individuality.				
F85	2. Each resident is given privacy during treatment and care of personal needs.				
F86	3. Each resident's records, including information in an automated data bank, are treated confidentially.				
F87	4. Each resident must give written consent before the facility releases information from his/her record to someone not otherwise authorized to receive it.				
F88	5. Married residents are given privacy during visits by their spouses.				
F89	6. Married residents are permitted to share a room.				
	H. Work				
F90	No resident may be required to perform services for the facility.				

NAME OF FACILITY		GOVERNING BODY		YES	NO	N/A	EXPLANATORY STATEMENT
CODE							
	I. Freedom of Association and Correspondence						
F91	1. Each resident is allowed to communicate, associate and meet privately with individuals of his/her choice unless this infringes upon the rights of another resident.						
F92	2. Each resident is allowed to send and receive personal mail unopened.						
	J. Activities						
F93	Each resident is allowed to participate in social, religious, and community group activities.						
	K. Personal Possessions						
F94	Each resident is allowed to retain and use his/her personal possessions and clothing as space permits.						
	L. Delegation of Rights and Responsibilities						
F95	ICF (442.312) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET						
F96	1. All the rights and responsibilities of a resident pass to the resident's guardian, next of kin or sponsoring agency or agencies if the resident is adjudicated incompetent under State law or is determined by his/her physician to be incapable of understanding his/her rights and responsibilities.						
F97	2. Physician determinations of incapability and the specific reasons thereof are recorded by the physician in the resident's record.						

NAME OF FACILITY					
CODE	GOVERNING BODY	YES	NO	N/A	EXPLANATORY STATEMENT
F98	STAFF DEVELOPMENT SNF (405.1121(h)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F99	ICF (442.314) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F100	1. Facility staff are knowledgeable about the problems and needs of the aged, ill, and disabled.				
F101	2. Facility staff practices proper techniques in providing care to the aged, ill, and disabled.				
F102	3. Facility staff practice proper technique for prevention and control of infection, fire prevention and safety, accident prevention, confidentiality of resident information, and preservation of resident dignity, including protection of privacy and personal and property rights.				
STATUS CHANGE NOTIFICATIONS					
F103	SNF (405.1121(j)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F104	ICF (442.307) (Standard) <input type="checkbox"/> Met <input type="checkbox"/> Not Met				
F105	1. The facility notifies the resident's attending physician and other responsible persons in the event of an accident involving the resident, or other significant change in the resident's physical, mental, or emotional status, or resident charges, billings, and related administrative matters.				
F106	2. Except in a medical emergency, a resident is not transferred or discharged, nor is treatment altered radically, without consultation with the resident or, if the resident is incompetent, without prior notification of next of kin or sponsor.				

NAME OF FACILITY		PHYSICIANS' SERVICES		YES	NO	N/A	EXPLANATORY STATEMENT
CODE	PHYSICIANS' SERVICES (CONDITION OF PARTICIPATION)						
F107	SNF (405.1123) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET						
A. Medical Findings and Orders at Time of Admission							
F108	SNF (405.1123(a)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET						
F109	1. There is made available to the facility prior to or at the time of admission, resident information which includes current medical findings, diagnoses, and orders from a physician for immediate care of the resident.						
F110	2. Information about the rehabilitation potential of the resident and a summary of prior treatment are made available to the facility at the time of admission or within 48 hours thereafter.						

NAME OF FACILITY _____

CODE	PHYSICIANS' SERVICES	YES NO N/A			EXPLANATORY STATEMENT
	B. Resident Supervision by Physician				
F111	SNF (405.1123(b)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F112	ICF (442.346) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET Indicators B and C apply to this standard for ICFS.				
F113	1. Every resident must be under the supervision of a physician.				
F114	2. A physician prescribes a planned regimen of care based on a medical evaluation of each resident's immediate and long-term care needs. Exception: Not required for ICF residents				
F115	3. A physician is available to provide care in the absence of any resident's attending physician.				
F116	4. Medical evaluation is done within 48 hours of admission unless done within 5 days prior to admission. Exception: Not required for ICF residents.				
F117	5. Each resident is seen by their attending physician at least once every 30 days for the first 90 days after admission. Exception: ICF residents must be seen every 60 days unless otherwise justified and documented by the attending physician.				
F118	6. Each resident's total program of care including medications and treatments is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days and revised as necessary. Exception: Only medications must be reviewed quarterly for ICF residents.				

NAME OF FACILITY		PHYSICIANS' SERVICES/NURSING SERVICES		YES	NO	N/A	EXPLANATORY STATEMENT
CODE		7. Progress notes are written and signed by the physician at the time of each visit, and all orders are signed by the physician.					
F119							
F120		8. Alternate physician visit schedules that exceed a 30-day schedule adopted after the 90th day following admission are justified by the attending physician in the medical record. These visits cannot exceed 60 days or apply to residents who require specialized rehabilitation schedules. EXCEPTION: Not required for ICF residents.					
		C. Emergency Services					
F121		SNF (405.1123(c)) (Standard)	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F122		Emergency services from a physician are available and provided to each resident who requires emergency care.					
		NURSING SERVICES (CONDITION OF PARTICIPATION)					
F123		SNF (405.1124)	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F124		SNF (405.1124(c)) (Standard)	<input type="checkbox"/> Met <input type="checkbox"/> Not Met				
		Indicators A and B apply to this standard for SNFs					
F125		ICF (442.338)	<input type="checkbox"/> Met <input type="checkbox"/> Not Met				
		Indicators A thru E apply to this standard for ICFs except where noted.					
		A. The facility provides nursing services which are sufficient to meet nursing needs of all residents all hours of each day.					
F126		1. Each resident receives all treatments, medications and diet as prescribed. Deviations are reported and appropriate action is taken.					

NAME OF FACILITY

CODE	NURSING SERVICES	YES	NO	N/A	EXPLANATORY STATEMENT
F127	2. Each resident receives daily personal hygiene as needed to assure cleanliness, good skin care, good grooming, and oral hygiene taking into account individual preferences. Residents are encouraged to engage in self care activity.				
F128	3. Each resident receives care necessary to prevent skin breakdown.				
F129	4. Each resident with a decubitus receives care necessary to promote the healing of the decubitus including proper dressing.				
F130	5. When residents require restraints the application is ordered by the physician, applied properly, and released at least every 2 hours.				
F131	6. Each resident with incontinence is provided with care necessary to encourage continence including frequent toileting and opportunities for rehabilitative training.				
F132	7. Each resident with a urinary catheter receives proper routine care including periodic evaluation.				
F133	8. Each resident receives proper care for the following needs: Injections Parenteral Fluids Colostomy/Ileostomy Respiratory Care Tracheostomy Care Suctioning Tube Feeding				
F134	9. Infection Control Techniques are properly carried out in the provision of care to each resident.				

NAME OF FACILITY		NURSING SERVICES		YES	NO	N/A	EXPLANATORY STATEMENT
F135	10. Proper nursing and sanitary procedures and techniques are used when medications are given to residents.						
F136	11. Adequate resident care supplies are available for providing treatments.						
F137	B. Twenty-Four Hour Nursing Service 1. Nursing personnel, including registered nurses, licensed practical (vocational) nurses, nurse aides, orderlies, and ward clerks, are assigned duties consistent with their education and experience, and based on the characteristics of the resident load. EXCEPTION: Not required for ICFs.						
F138	2. Weekly time schedules are maintained and indicate the number and classifications of nursing personnel including relief personnel, who worked on each unit for each tour of duty. (If a distinct part certification, show the staffing for the DP and, if appropriate, any nonparticipating remainder and explain any sharing of nursing personnel.) Exception: Not required for Freestanding ICFs.						
F139	3. There is a sufficient number of nursing staff available to meet the total needs of all residents.						
F140	4. There is a registered nurse on the day tour of duty 7 days a week. Exception: Not required for ICF residents.						

NAME OF FACILITY

CODE	NURSING SERVICES	YES	NO	N/A	EXPLANATORY STATEMENT
	C. Charge Nurse				
F141	SNF (405.1124(b)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F142	1. A registered nurse or a qualified licensed practical (or vocational) nurse is designated as charge nurse by the director of nursing for each tour of duty. Exception: Not required for ICFs.				
F143	2. The director of nursing services does not serve as charge nurse in a facility with an average daily total occupancy of 60 or more residents. Exception: Not required for ICFs.				
F144	3. The ICF must have a registered nurse, or a licensed practical or vocational nurse full-time, 7 days a week, on the day shift. Exception: Not required for SNFs.				

NAME OF FACILITY

List the number of full-time equivalents of RN's, LPN's, Aides/Orderlies assigned to nursing duty from the last 3 complete weeks. (Note only actual staff on duty.)

Shift	CODE	Day 1			Day 2			Day 3			Day 4			Day 5			Day 6			Day 7		
		RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DAY	DP																					
	Entire Facility																					
EVENING	DP																					
	Entire Facility																					
NIGHT	DP																					
	Entire Facility																					

Shift	CODE	Day 1			Day 2			Day 3			Day 4			Day 5			Day 6			Day 7		
		RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DAY	DP																					
	Entire Facility																					
EVENING	DP																					
	Entire Facility																					
NIGHT	DP																					
	Entire Facility																					

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NAME OF FACILITY

	Shift	CODE	Day 1			Day 2			Day 3			Day 4			Day 5			Day 6			Day 7		
			RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DAY	DP	F151																					
	Entire Facility	F152																					
EVENING	DP	F153																					
	Entire Facility	F154																					
NIGHT	DP	F155																					
	Entire Facility	F156																					

STAFFING PATTERN WORKSHEETS DAY OF SURVEY (OPTIONAL)

ENTIRE FACILITY STAFFING PATTERN (DAY OF SURVEY)

	CODE		RN	PN	A
DAY	F157	REPORT			
	F158	ACTUAL			
EVENING	F159	REPORT			
	F160	ACTUAL			
NIGHT	F161	REPORT			
	F162	ACTUAL			

UNIT STAFFING PATTERN WORKSHEET (DAY OF SURVEY)

	CODE	Unit			Unit			Unit			Unit			Unit			Unit		
		RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DAY	F163																		
EVENING	F164																		
NIGHT	F165																		
CENSUS	F166																		

NAME OF FACILITY		NURSING SERVICES		YES	NO	N/A	EXPLANATORY STATEMENT
D. PATIENT CARE MANAGEMENT							
F167	SNF (405.1124(d)) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F168	ICF (442.341) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F169	1. Each resident's needs are addressed in a written plan of care which demonstrates that the plans of all services are integrated, consonant with the physician's plan of medical care, and implemented shortly after admission.						
F170	2. Each professional service identifies needs, goals, plans, and evaluates the effectiveness of interventions, plus institutes changes in the plan of care in a timely manner.						
	E. Rehabilitative Nursing Services are performed daily, and recorded for those residents who require such service.						
F171	SNF (405.1124(e)) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F172	ICF (442.342) (Standard)	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met				
F173	1. Each resident receives rehabilitative nursing care to promote maximum physical functioning to prevent immobility, deformities, and contractures.						
F174	2. There is an ongoing evaluation of each resident's rehabilitative nursing needs. This may include:						
F175	(a) Range of motion, ambulation, turning and positioning and other activities;						
F176	(b) Assistance and instruction in the activities of daily living such as feeding, dressing, grooming, oral hygiene and toilet activities;						
F177	(c) Remotivation therapy and/or reality orientation when appropriate.						
F178	3. These activities are coordinated with other resident care services.						

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NAME OF FACILITY

CODE	NURSING SERVICES	YES	NO	N/A	EXPLANATORY STATEMENT
	F. The facility has an awareness of nutritional needs and fluid intake of residents and provides prompt assistance where necessary in feeding residents.				
F179	SNF (405.1124(f)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F180	1. Each resident is provided with the amount of food and fluid on a daily basis necessary to maintain their appropriate minimum average weight. Between meal feedings are offered and the amount consumed is observed. Daily food and fluid intake is observed and encouraged.				
F181	2. Each resident needing assistance in eating or drinking is provided prompt assistance. Specific self-help devices are available when necessary.				
F182	3. Deviations from normal food and fluid intake are recorded and reported to the charge nurse and the attending physician.				

NAME OF FACILITY		NURSING SERVICES		YES	NO	N/A	EXPLANATORY STATEMENT
		G. Administration of Drugs					
F183		SNF (405.1124(g)) (Standard)	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F184		ICF (442.337) (Standard)	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F185		1. The resident is identified prior to administration of a drug.					
F186		2. Drugs and biologicals are administered as soon as possible after doses are prepared.					
F187		3. Administered by same person who prepared the doses for administration except under single unit dose package distribution systems.					
F188		Exception: ICF residents may self administer medication only with their physician's permission.					
		H. Conformance with Physician Drug Orders					
F189		SNF (405.1124(h)) (Standard)	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F190		ICF (442.334) (Standard)	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F191		Drugs are administered in accordance with written orders of the attending physician.					
F192		Drug Error Rate _____ % (See Form IICPA-522)					

NAME OF FACILITY _____

CODE	DIETETIC SERVICES	YES	NO	N/A	EXPLANATORY STATEMENT
DIETETIC SERVICES (CONDITION OF PARTICIPATION)					
F193	SNF (405.1125) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F194	ICF (442.332) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET Indicators A and B apply to this standard for ICFS.				
A. Menus and Nutritional Adequacy					
F195	SNF (405.1125(b)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F196	Menus are planned and followed to meet the nutritional needs of each resident in accordance with physicians' orders and, to the extent medically possible, based on the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.				
B. Therapeutic Diets					
F197	SNF (405.1125(c)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F198	1. Therapeutic diets are prescribed by the attending physician.				
F199	2. Therapeutic menus are planned in writing, prepared, and served as ordered with supervision from the dietitian and advice from the physician whenever necessary.				
F200	Number of Regular Diets _____				
F201	Number of Therapeutic Diets _____				
F202	Number of Mechanically Altered Diets _____				
F203	Number of Tube Feedings _____				

NAME OF FACILITY		DIETETIC SERVICES		YES	NO	N/A	EXPLANATORY STATEMENT
C. Preparation							
F204	SNF (405.1125(e)) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F205	1. Food is prepared by methods that conserve its nutritive value and flavor.						
F206	2. Meals are palatable, served at proper temperatures. They are cut, ground, chopped, pureed or in a form which meets individual resident needs.						
F207	3. If a resident refuses food served, appropriate substitutes of similar nutritive value are offered.						
D. Frequency							
F208	SNF (405.1125(d)) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F209	ICF (442.331) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F210	1. At least three meals are served daily at regular hours with not more than a 14-hour span between a substantial evening meal and breakfast.						
F211	2. To the extent medically possible, bedtime nourishments are offered to all residents.						
Exception: Not required for ICF Residents.							
E. Staffing							
F212	SNF (405.1125(a)) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F213	1. Food service personnel are on duty daily over a period of 12 or more hours.						

NAME OF FACILITY

CODE	SPECIALIZED REHABILITATIVE SERVICES	YES	NO	N/A	EXPLANATORY STATEMENT
	SPECIALIZED REHABILITATIVE SERVICES (CONDITION OF PARTICIPATION)				
F214	SNF (405.1126) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F215	SNF (405.1126(b)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F216	ICF (442.343) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
	A. Plan of Care				
F217	Rehabilitative services are provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapists(s) and the nursing service.				
	B. Therapy				
F218	Therapy is provided according to orders of the attending physician in accordance with accepted professional practices by qualified therapists or qualified assistants.				
	C. Progress				
F219	1. A report of the resident's progress is communicated to the attending physician within 2 weeks of the initiation of specialized rehabilitative services. Exception: ICF resident's progress must be reviewed regularly.				

NAME OF FACILITY		YES		NO		N/A		EXPLANATORY STATEMENT
CODE	SPECIALIZED REHABILITATIVE SERVICES/PHARMACEUTICAL SERVICES							
F220	2. The resident's progress is thereafter reviewed regularly, and the plan of rehabilitative care is reevaluated as necessary, but at least every 30 days, by the physician and the therapist. Exceptions: ICF residents' plans must be revised as necessary.							
	PHARMACEUTICAL SERVICES (CONDITION OF PARTICIPATION)							
F221	SNF (405.1127) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET							
	A. Supervision							
F222	SNF (405.1127(a)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET							
F223	ICF (442.336) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET							
F224	The pharmacist reviews the drug regimen of each resident at least monthly and reports any irregularities to the medical director and administrator.							

NAME OF FACILITY

CODE	PHARMACEUTICAL SERVICES		YES	NO	N/A	EXPLANATORY STATEMENT
	LABORATORY AND RADIOLOGIC SERVICES/SOCIAL SERVICES					
B. Labeling of Drugs and Biologicals						
F225	SNF (405.1127(c)) (Standard)	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F226	ICF (442.333) (Standard)	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F227	The labeling of drugs and biologicals is based on currently accepted professional principles and includes the appropriate accessory and cautionary instructions as well as an expiration date when applicable.					
LABORATORY AND RADIOLOGIC SERVICES (CONDITION OF PARTICIPATION)						
F228	SNF (405.1128)	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F229	SNF (405.1128(a)) (Standard)	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
Provision of Services						
F230	1. All services are provided only on the orders of a physician.					
F231	2. The attending physician is notified promptly of diagnostic findings.					
F232	3. Signed and dated reports of a clinical laboratory, X-ray and other diagnostic services are filed with the resident's medical record.					

NAME OF FACILITY		YES		NO		N/A		EXPLANATORY STATEMENT
CODE	SOCIAL SERVICES/ACTIVITIES							
	SOCIAL SERVICES (CONDITION OF PARTICIPATION)							
F233	SNF (405.1130) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET							
F234	SNF (405.1130(a)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET							
F235	ICF (442.344) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET							
	A. Plan							
F236	The medically related social and emotional needs of the resident are identified.							
	B. Provision of Services							
F237	1. Services are provided to meet the social and emotional needs by the facility or by referral to an appropriate social agency.							
F238	2. If financial assistance is indicated, arrangements are made promptly for referral to an appropriate agency.							
	ACTIVITIES (CONDITION OF PARTICIPATION)							
F239	SNF(405.1131) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET							
	Provision of Services							
F240	SNF (405.1131(b)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET							

NAME OF FACILITY

CODE	ACTIVITIES	YES	NO	N/A	EXPLANATORY STATEMENT
F241	ICF (442.345) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F242	1. An ongoing program of meaningful activities is provided based on identified needs and interests of each resident. It is designed to promote opportunities for engaging in normal pursuits, including religious activities of their choice, if any.				
F243	2. Unless contraindicated by the attending physicians each resident is encouraged to participate in the activities program.				
F244	3. The activities promote the physical, social and mental well-being of the resident.				
F245	4. Equipment is maintained in good working order.				
F246	5. Supplies and equipment are available.				

NAME OF FACILITY		YES		NO		N/A		EXPLANATORY STATEMENT
CODE	MEDICAL RECORDS (CONDITION OF PARTICIPATION)							
F247	SNF (405.1132)	<input type="checkbox"/>	MET	<input type="checkbox"/>	NOT MET			
	Content							
F248	SNF (405.1132(c)) (Standard)	<input type="checkbox"/>	MET	<input type="checkbox"/>	NOT MET			
F249	ICF (442.318) (Standard)	<input type="checkbox"/>	MET	<input type="checkbox"/>	NOT MET			
F250	1. The medical record contains sufficient information to identify the resident clearly, to justify diagnoses and treatment, and to document results accurately.							

NAME OF FACILITY					
CODE	MEDICAL RECORDS	YES	NO	N/A	EXPLANATORY STATEMENT
	2. The medical record contains the following information:				
F251	a. Identification information				
F252	b. Admission data including past medical and social history				
F253	c. Transfer form, discharge summary from any transferring facility				
F254	d. Report of resident's attending physician				
F255	e. Report of physical examinations				
F256	f. Reports of physicians' periodic evaluations and progress notes				
F257	g. Diagnostic reports and therapeutic orders				
F258	h. Reports of treatments				
F259	i. Medications administered				
F260	j. An overall plan of care setting forth goals to be accomplished through each service's designed activities, therapies and treatments.				
F261	k. Assessments and goals of each service's plan of care				
F262	l. Treatments and services rendered				
F263	m. Progress notes				
F264	n. All symptoms and other indications of illness or injury including date, time and action taken regarding each problem.				

NAME OF FACILITY		YES		NO		N/A		EXPLANATORY STATEMENT
CODE	TRANSFER AGREEMENT (CONDITION OF PARTICIPATION)							
F265	SNF (405.1133)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
F266	SNF (405.1133(a)) (Standard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
F267	ICF (442.316) (Standard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
F268	A. Whenever the attending physician determines that a transfer is medically appropriate between a hospital or a facility providing more specialized care and the nursing facility, admission to the new facility shall be effected in a timely manner. B. Information necessary for providing care and treatment to transferred individuals is provided.							
F269								

NAME OF FACILITY _____

CODE	PHYSICAL ENVIRONMENT	YES	NO	N/A	EXPLANATORY STATEMENT
	PHYSICAL ENVIRONMENT (CONDITION OF PARTICIPATION)				
F270	SNF (405.1134) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
	A. Nursing Unit				
F271	SNF (405.1134(d)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F272	1. The unit is properly equipped for preparation and storage of drugs and biologicals.				
F273	2. Utility and storage rooms are adequate in size.				
F274	3. The unit is equipped to register resident calls with a functioning communication system from resident areas including resident rooms and toilet and bathing facilities.				
	B. Dining and Activities Area				
F275	SNF (405.1134(g)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F276	ICF (442.329) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F277	1. The facility provides one or more clean, orderly and appropriately furnished rooms of adequate size, designated for resident dining and resident activities.				
F278	2. Dining and activity rooms are well lighted and ventilated.				
F279	3. Any multipurpose room used for dining and resident activities has sufficient space to accommodate all activities and prevent their interference with each other.				

NAME OF FACILITY		PHYSICAL ENVIRONMENT		YES	NO	N/A	EXPLANATORY STATEMENT
CODE							
F280	SNF (405.1134(e)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET						
	INDICATORS C AND D APPLY TO THIS STANDARD FOR SNF						
	C. Resident Rooms						
F281	ICF (442.325) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET						
F282	1. Single resident rooms have at least 100 square feet.						
F283	2. Multiple resident rooms have no more than four residents and at least 80 square feet per resident.						
F284	3. Each room is equipped with or conveniently located near toilet and bathing facilities.						
F285	4. There is capability of maintaining privacy in each.						
F286	5. There is adequate storage space for each resident.						
F287	6. There is a comfortable and functioning bed and chair plus a functional cabinet and light.						
F288	7. The resident call system functions in resident rooms.						
F289	8. Each room is designed and equipped for adequate nursing care and the comfort and privacy of the residents.						
F290	9. Each room is at or above grade level.						
F291	10. Each room has direct access to a corridor and outside exposure.						
	Exception: Not required for ICF residents.						

NAME OF FACILITY

CODE	PHYSICAL ENVIRONMENT	YES	NO	N/A	EXPLANATORY STATEMENT
	D. Toilet and Bath Facilities				
F292	ICF (442.326) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F293	1. Facilities are clean, sanitary and free of odors.				
F294	2. Facilities have safe and comfortable hot water temperatures.				
F295	3. Facilities maintain privacy.				
F296	4. Facilities have grab bars and other safeguards against slipping.				
F297	5. Facilities have fixtures in good condition.				
F298	6. The resident call system functions in toilet and bath facilities.				
	E. Social Service Area				
F299	SNF (405.1130(b)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F300	1. Ensures privacy for social service interviewing.				
F301	2. Adequate space for clerical and interviewing functions is provided.				
F302	3. Facilities are easily accessible to residents and staff.				

NAME OF FACILITY		PHYSICAL ENVIRONMENT		YES	NO	N/A	EXPLANATORY STATEMENT
F. Therapy Areas							
F303	SNF (405.1128(a)) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F304	ICF (442.328(a))	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F305	1. Space is adequate for proper use of equipment by all residents receiving treatments.						
F306	2. Equipment is safe and in proper working condition.						
G. Facilities for Special Care							
F307	SNF (405.1134(i)) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F308	ICF (442.328(b))	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F309	1. Single rooms with private toilet and handwashing facilities are available for isolating residents.						
F310	2. Precautionary signs are used to identify these rooms when in use.						
H. Common Resident Areas							
F311	SNF (405.1134(j)) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F312	ICF (442.324) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F313	1. All common resident areas are clean, sanitary and free of odors.						
F314	2. Provision is made for adequate and comfortable lighting levels in all areas.						
F315	3. There is limitation of sounds at comfort levels.						

NAME OF FACILITY					
CODE	PHYSICAL ENVIRONMENT	YES	NO	N/A	EXPLANATORY STATEMENT
F316	4. A comfortable room temperature is maintained.				
F317	5. There is adequate ventilation through windows or mechanical means or a combination of both.				
F318	6. Corridors are equipped with firmly secured handrails on each side.				
F319	7. Staff are aware of procedures to ensure water to all essential areas in the event of loss of normal supply.				
I. Maintenance of Building and Equipment					
F320	SNF (405.1134(i)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F321	1. The interior and exterior of the building are clean and orderly.				
F322	2. All essential mechanical and electrical equipment is maintained in safe operating condition.				
F323	3. Sufficient storage space is available and used for equipment to ensure that the facility is orderly and safe.				
F324	4. Resident care equipment is clean and maintained in safe operating condition.				
F325	ICF (442.331(b)) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET Indicators J thru L apply to ICFs.				
J. Dietetic Service Area					
F326	SNF (405.1134(h)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F327	1. Kitchen and dietetic service areas are adequate to insure proper, timely food services for all residents				
F328	2. Kitchen areas are properly ventilated, arranged, and equipped for storage and preparation of food as well as for dish and utensil cleaning, and refuse storage and removal.				

NAME OF FACILITY		PHYSICAL ENVIRONMENT/INFECTION CONTROL		YES	NO	N/A	EXPLANATORY STATEMENT
K. HYGIENE OF DIETARY STAFF							
F329	SNF (405.1125(f)) (Standard)	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met				
F330	Dietetic service personnel practice hygienic food handling techniques.						
L. DIETARY SANITARY CONDITIONS							
F331	SNF (405.1125(g)) (Standard)	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met				
F332	1. Food is stored, refrigerated, prepared, distributed, and served under sanitary conditions.						
F333	2. Waste is disposed of properly.						
M. Emergency Power							
F334	SNF (405.1134(b)) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F335	1. An emergency source of electrical power necessary to protect the health and safety of residents is available in the event the normal electrical supply is interrupted.						
F336	2. Emergency power is adequate at least for lighting in all means of egress; equipment to maintain fire detection, alarm, and extinguishing systems; and life safety support systems.						
F337	3. Emergency power is provided by an emergency electrical generator located on the premises where life support systems are used.						
INFECTION CONTROL (CONDITION OF PARTICIPATION)							
F338	SNF (405.1135)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
A. Infection Control							
F339	SNF (405.1135(b)) (Standard)	<input type="checkbox"/> MET	<input type="checkbox"/> NOT MET				
F340	Aseptic and isolation techniques are followed by all personnel.						

NAME OF FACILITY

CODE	INFECTION CONTROL/DISASTER PREPAREDNESS	YES	NO	N/A	EXPLANATORY STATEMENT
	B. Sanitation				
F341	SNF (405.1135(c)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F342	The facility maintains a safe, clean, and orderly interior.				
	C. Linen				
F343	SNF (405.1135(d)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F344	ICF (442.327) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F345	1. The facility has available at all times a quantity of linen essential for proper care and comfort of residents.				
F346	2. Linens are handled; stored, processed, and transported in such a manner as to prevent the spread of infection.				
	D. PEST CONTROL				
F347	SNF (405.1135(e)) (Standard) <input type="checkbox"/> Met <input type="checkbox"/> Not Met				
F348	ICF (442.315(c)) (Standard) <input type="checkbox"/> Met <input type="checkbox"/> Not Met				
F349	The facility is maintained free from insects and rodents.				
	DISASTER PREPAREDNESS (CONDITION OF PARTICIPATION)				
F350	SNF (405.1136) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F351	SNF (405.1136(a)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				
F352	ICF (442.313) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET Indicators A and B apply to this standard for ICFS.				
	A. Disaster Plan				
F353	1. Facility staff are aware of plans, procedures to be followed for fire, explosion or other disaster.				

NAME OF FACILITY		DISASTER PREPAREDNESS		YES	NO	N/A	EXPLANATORY STATEMENT
F354	2. Facility staff are knowledgeable about evacuation routes.						
F355	3. Facility staff are aware of their specific responsibilities in regard to evaluation and protection of residents.						
F356	4. Facility staff are aware of methods of containing fire.						
	B. Drills						
F357	SNF (405.1136(b)) (Standard) <input type="checkbox"/> MET <input type="checkbox"/> NOT MET						
F358	1. All employees are trained, as part of their employment orientation in all aspects of preparedness for any disaster.						
F359	2. Facility staff participate in ongoing training and drills in all procedures so that each employee promptly and correctly carries out a specific role in case of a disaster.						

SKILLED NURSING FACILITY & INTERMEDIATE CARE FACILITY <small>SURVEY REPORT — PART B CRUCIAL DATA EXTRACT (To be used with 2-86 Revision of Form HCFA-519)</small>		
PROVIDER NO.	FACILITY NAME	SURVEY DATE
SURVEY TEAM COMPOSITION		
*F1: INDICATE THE NUMBER OF SURVEYORS ACCORDING TO DISCIPLINE:		
A. _____ ADMINISTRATOR B. _____ NURSE C. _____ DIETITIAN D. _____ PHARMACIST E. _____ RECORDS ADMINISTRATOR F. _____ SOCIAL WORKER G. _____ QUALIFIED MENTAL RETARDATION PROFESSIONAL	H. _____ LIFE SAFETY CODE SPECIALIST I. _____ LABORATORIAN J. _____ SANITARIAN K. _____ THERAPIST L. _____ PHYSICIAN M. _____ NATIONAL INSTITUTE OF MENTAL HEALTH N. _____ OTHER	
NOTE: MORE THAN ONE DISCIPLINE MAY BE MARKED FOR SURVEYORS QUALIFIED IN MULTIPLE DISCIPLINES.		
*F2: INDICATE THE TOTAL NUMBER OF SURVEYORS ONSITE: _____		
*F193 DRUG ERROR RATE: _____ % (Round % to nearest whole number.)		
*SF5 Survey Form Indicator (Check one) <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> Traditional Survey (1) <input type="checkbox"/> </div> <div style="text-align: center;"> New LTC Survey (2) <input type="checkbox"/> </div> </div>		
NOTE: PLEASE ATTACH COPY OF PAGES 2, 14 AND 15.		

*Mandatory

Form HCFA-519E (2-86)

★U.S. GOVERNMENT PRINTING OFFICE : 1986 O - 153-203 : QL 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION		FORM APPROVED OMB NO. 0938-0400	
RESIDENTS SELECTED FOR INDEPTH REVIEW			
PROVIDER NUMBER	SURVEY DATE	ROOM NUMBER	REASON FOR SELECTION
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
FORM HCFA-520 (2-86)		* NOTE IF ICF OR SNF RESIDENT	
		* U.S. GPO 1986 O-181-264/3339	

TOUR NOTES WORKSHEET

PROVIDER NUMBER	SURVEY DATE
INSTRUCTIONS	
1. Note care and problems in care on all units. 2. Report deficiencies directly to survey report form or evaluate further during indepth sample review. 3. Select residents for indepth review. 4. Select a proportionate number from each section.	
INDEPTH SAMPLE	
Facility Census 0-60 61-120 121-200 200+	
Sample 25% 20% 15% (Min30) 10%	
Size (Min10) (Min15) (Min24) (Max50)	
OBSERVE RESIDENTS FOR THE FOLLOWING CARE PROBLEMS	
GROOMING/PERSONAL HYGIENE	
POSITIONING	
ASSISTIVE DEVICES	
AMBULATION	
RESTRAINTS	
HYDRATION	
INFECTION CONTROL	
PATIENT RIGHTS	
OTHER	

FORM HCFA-521 (2-86)

FORM APPROVED
OMB NO. 0938-0400DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OBSERVATION / INTERVIEW RECORD REVIEW WORKSHEET

PROVIDER NUMBER	SURVEY DATE	OBSERVATION/INTERVIEW OF: (RESIDENT IDENTIFIER)				
INSTRUCTIONS						
<p>1. Observe each resident in sample to identify ADL needs and potential problems. Check appropriate blocks.</p> <p>2. Interview only residents in sample who are capable and willing.</p> <p>3. Review each resident's record to ensure assessments, plans, interventions and evaluations are appropriate and current.</p> <p>4. Note deficiencies on survey report form after reviewing all residents in sample.</p>						
RESIDENT NEEDS						
ADL's <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Transferring <input type="checkbox"/> Continence <input type="checkbox"/> Feeding SKIN <input type="checkbox"/> Sores/Wounds <input type="checkbox"/> Ulcers <input type="checkbox"/> Rash <input type="checkbox"/> Flaking <input type="checkbox"/> Scaling <input type="checkbox"/> Red Area DECELIBITUS <input type="checkbox"/> Good <input type="checkbox"/> Foul Odor <input type="checkbox"/> Draining <input type="checkbox"/> Unclean <input type="checkbox"/> Not Dry <input type="checkbox"/> Not Intact <input type="checkbox"/> Poor Technique	GROOMING/HYGIENE <input type="checkbox"/> Eyes/Ears/Mouth <input type="checkbox"/> Oral/Dental Hygiene <input type="checkbox"/> Facial Hair <input type="checkbox"/> Hair/Scalp <input type="checkbox"/> Nails <input type="checkbox"/> Clothing <input type="checkbox"/> Shoes/Slippers <input type="checkbox"/> Odors POSITIONING <input type="checkbox"/> Need Present <input type="checkbox"/> Contracted <input type="checkbox"/> Extremities <input type="checkbox"/> Improper Position <input type="checkbox"/> Lack of Flexion Device <input type="checkbox"/> ROM Limited <input type="checkbox"/> Lack of Turning as Needed <input type="checkbox"/> Schedule Not Present <input type="checkbox"/> Improper Techniques <input type="checkbox"/> Aspic/Other DRESSINGS <input type="checkbox"/> Present <input type="checkbox"/> Unclean <input type="checkbox"/> Not Intact <input type="checkbox"/> Foul Odor <input type="checkbox"/> Poor Technique	RESTRAINTS <input type="checkbox"/> Type <input type="checkbox"/> Inappropriate Application <input type="checkbox"/> Misuse <input type="checkbox"/> Alignment/Support <input type="checkbox"/> Not Released/Exercised <input type="checkbox"/> Every 2 Hours <input type="checkbox"/> Chemically Restrained BOWEL/BLADDER <input type="checkbox"/> Not Routinely Toileted <input type="checkbox"/> Commode Not Available <input type="checkbox"/> Schedule Not Available CATHETER <input type="checkbox"/> Present <input type="checkbox"/> Inappropriate <input type="checkbox"/> Poor Drainage <input type="checkbox"/> No Urine in Bag <input type="checkbox"/> Urine Leaking <input type="checkbox"/> Abdomen Distended <input type="checkbox"/> No I/O Recording <input type="checkbox"/> Supply Storage Unclean INJECTIONS <input type="checkbox"/> Receives Injections <input type="checkbox"/> Site Red/Swollen <input type="checkbox"/> Improper Technique <input type="checkbox"/> Resident Resists	COLOSTOMY/ILEOSTOMY <input type="checkbox"/> Present <input type="checkbox"/> Not Well Regulated <input type="checkbox"/> Odor <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Site Red/Irritated PARENTERAL FLUIDS/IV'S <input type="checkbox"/> Present <input type="checkbox"/> Site Incorrect/Stopped <input type="checkbox"/> Site Irritated <input type="checkbox"/> Dressing Unclean <input type="checkbox"/> Unstable Spinal <input type="checkbox"/> Improper Label <input type="checkbox"/> Outdated Solution <input type="checkbox"/> No I/O Recording TRACHEOSTOMY <input type="checkbox"/> Present <input type="checkbox"/> Site Red/Swollen <input type="checkbox"/> Unclean <input type="checkbox"/> Obstructed <input type="checkbox"/> Improper Suctioning <input type="checkbox"/> Equipment Not Available SUCTIONING <input type="checkbox"/> Audible Rates <input type="checkbox"/> Labored Breathing <input type="checkbox"/> Drainage <input type="checkbox"/> Equipment Not Available	RESPIRATORY <input type="checkbox"/> Congested/Short <input type="checkbox"/> Breath <input type="checkbox"/> Oxygen Not Available <input type="checkbox"/> Oxygen Not Available <input type="checkbox"/> Improper Equipment Use DIETARY NEEDS <input type="checkbox"/> Over/Underweight <input type="checkbox"/> Dehydrated <input type="checkbox"/> Emaciated <input type="checkbox"/> Dull/Dry Hair <input type="checkbox"/> Swollen/Red Tongue <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Cracked Lips <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Swallowing Prob. <input type="checkbox"/> Pallor	REHABILITATION NEEDS <input type="checkbox"/> Cannot Communicate <input type="checkbox"/> Ineffective Use of Assistive Device <input type="checkbox"/> Improper Equipment Use <input type="checkbox"/> Equipment Inadequate SOCIAL SERVICE NEEDS <input type="checkbox"/> Not Assessed <input type="checkbox"/> Not Able to Converse <input type="checkbox"/> Uncooperative/Disrupts <input type="checkbox"/> Withdrawn <input type="checkbox"/> Anxious <input type="checkbox"/> Confused <input type="checkbox"/> Lonely <input type="checkbox"/> Hearing Needs <input type="checkbox"/> Mentally Retarded	ACTIVITY NEEDS <input type="checkbox"/> Not Participating <input type="checkbox"/> Not Participating <input type="checkbox"/> Over/Underweight <input type="checkbox"/> Dependence ≥ 4 ADL's PATIENT RIGHTS <input type="checkbox"/> Privacy Not Maintained <input type="checkbox"/> Staff Not Courteous <input type="checkbox"/> Not Informed of Rights <input type="checkbox"/> Not Physically Restrainted <input type="checkbox"/> Cannot Exercise Rights <input type="checkbox"/> Cannot Manage Affairs

NOTES:

SEE REVERSE

Form HCFA 524 (2-86)

[illegible]

DRUG ERROR CALCULATION
(SEE SOM Appendix N Part 2)

How to Calculate a Medication Error Rate—In calculating the percentage of errors, the numerator in the ratio is the total number of errors that you observe, both significant and non-significant. The denominator is all the doses observed being administered **plus** the doses ordered but not administered. The equation for calculating a medication error rate is as follows:

$$\text{Medication Error Rate} = \frac{\text{Number of errors observed}}{\text{Opportunities for errors}} \times 100$$

Where: Opportunities for errors equals the number of doses administered **plus** the number of doses ordered but not administered.

Comments

For example, you observed the administration of drugs to 20 patients. There were a total of 47 drugs administered (47 opportunities for errors). At the completion of the reconciliation of your Observations with the physicians' orders, you find that three medication errors were made in administration and one medication was omitted (ordered but not administered). The omitted dose is included in both the numerator and the denominator. Therefore, following the above formula, your equation would be as follows:

$$\frac{3 + 1}{47 + 1} \times 100 = 8.3\%$$

• U.S. GPO: 1988-O-181-264/53636

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION		FORM APPROVED OMB NO. 0938-0400
DINING AREA & EATING ASSISTANCE WORKSHEET		
PROVIDER NUMBER	SURVEY DATE	
TASKS 1. Observe Dining Area. 2. Note Meals Served/Review Physicians Orders.		INSTRUCTIONS 3. Note Assistance Provided. 4. Note Deficiencies on Survey Summary Form. * SAMPLE A MINIMUM OF FIVE (5) RESIDENTS *
1. DINING AREA AND MEALS a. Size does not restrict movement. b. Accommodates all residents. c. Cleanliness. d. Adequate/comfortable lighting. e. Adequate/comfortable ventilation.		
2. SERVING OF MEALS * a. Number of meals/time span between meal. b. Conformance to physicians order. c. Nutritional adequacy. d. Adequacy of portions. e. Residents eat approximately 75% of meals. f. Puree dishes served individually. g. Food cut, chopped or ground for individual resident needs. h. Acceptable taste. i. Proper temperature. j. Plates covered.		

FORM HCFA-523 (2-96)

SEE REVERSE

FORM APPROVED
OMB NO. 0938-0400

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

2. SERVING OF MEALS * (continued)

- k. Served promptly.
- l. Residents ready for meal when served.
- m. Attractive.
- n. Utensils available.
- o. Functional trays for bedfast residents.
- p. Salt, pepper, sugar, other condiments on resident's trays unless contraindicated.
- q. Medically able residents eating in dining area.
- r. Bedtime nourishment offered.

3. SUPERVISION OF RESIDENT NUTRITION

- a. Prompt assistance.
- b. Proper assistance (spoon-feeding; supervision or instruction to develop eating skills).
- c. Courteous and unhurried assistance.
- d. Self-help devices present (straws, easy grip utensils, special cup, etc.).
- e. Intake recorded/deviations from normal are reported.

FORM HCFA-523 (2-88)

* U.S. GPO: 1988 O-181-264/51834

§ 488.110 Procedural guidelines.

SNF/ICF Survey Process. The purpose for implementing a new SNF/ICF survey process is to assess whether the quality of care, as intended by the law and regulations, and as needed by the

resident, is actually being provided in nursing homes. Although the onsite review procedures have been changed, facilities must continue to meet all applicable Conditions/Standards, in order to participate in Medicare/Medicaid programs. That is, the methods used to